

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$273.00 for date of service 03/19/01.
- b. The request was received on 02/27/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. TWCC 62 forms
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II: No response found in the case file.
3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the Provider's 14 day response on 11/26/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.
4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 02/26/02

"The patient had **two different procedures to two separate sites**. The procedure code of 64718 was performed at the **elbow**, and the code 25085 was performed to the **wrist**. These procedures were performed through **two separate incisions**, which required additional preparation to each site. Therefore, these are two primary procedures and are to be paid in full as required in the ruling above."
2. Respondent: No position statement found in the case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/19/01.
2. The explanation of denial listed on the EOB is, "F-Fee Guidelines MAR Reduction."
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
03/19/01	25085	\$546.00	\$273.00	F	\$546.00	MFG SGR (I)(D)(1)(c)	According to the rule referenced, "Secondary or subsequent procedures performed in remote areas that are unrelated to the primary procedure and requiring additional preparation shall be reimbursed at the lesser of the provider's usual and customary fee or 100% of the MAR." Medical documentation indicates that the procedure was performed on the wrist, through a separate incision, to excise a possible Occult ganglion cyst. This indicates a separate procedure not related to the elbow surgery and additional reimbursement is recommended in the amount of \$273.00 .
Totals		\$546.00	\$273.00				The Requestor is entitled to reimbursement in the amount of \$273.00 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$273.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 14th day of February 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb